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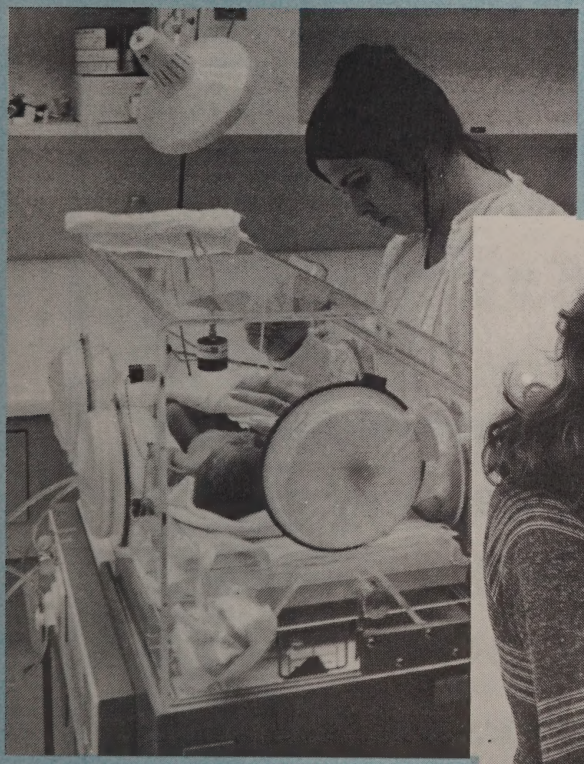

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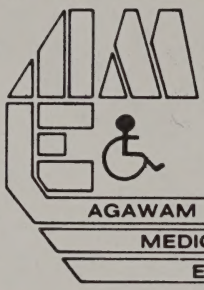


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# *From The Publication Committee*

As Chairman of the Publication Committee, I wish to thank the members of the Publication Committee and the Executive Committee for the opportunity to dedicate this issue to celebrate the 50th Anniversary of the founding of the American Academy of Pediatrics. As a pediatrician I am especially proud of our accomplishments and aware of challenges in the next 50 years. The goal in the medical management of children is to permit them to come into adulthood at their optimal state of development physically, mentally, socially, and intellectually, so that they can compete at their most effective level. The individulization of the child is the essence of pediatric care. We are especially proud to observe the disappearance of diphtheria, poliomyelitis, tetanus, rheumatic fever, measles, mumps, german measles, whooping cough and tuberculosis. Cancers once fatal such as leukemia can be brought under control.

The problems of society will provide the challenges in the next 50 years. We are seeing the beginning of the problems. Accidents are the number 1 killer starting at age one. Auto accidents are the leading cause of death from age 5 through 19. Suicide become the 2nd leading cause by age 20. The most pressing problem is teenage pregnancy. In Massachusetts more than 10,000 babies were born in 1978 to mothers 19 years or younger. Child Abuse is another serious problem. Teenagers account for 20% of the 10,000 new cases of gonorrhea reported in Massachusetts annually. School failure, emotional problems, violent behavior, drug addiction are other major problems.

Our thanks also goes to Governor Edward J. King; Dr. Sprague Hazard for his excellent discussion on the challenges in Pediatrics in his article 'An Agenda For America's Children'; Dr. Thomas M. Teree for 'Society in Transition'; Dr. Terrence M. O'Neill for 'Contraception for the Teenager'; (and Dr. Bhavest Shah on 'Neonatalogy').

Our response has been so over-whelming that the following articles will be in the March issue. 'Hyperkinesis and Stimulant Medicaiton', by Dr. Matthew R. Friedman; 'Child Abuse', by Dr. Edward N. Bailey; 'Orthopedic Screening', by Dr. Garry Hough, III; 'Neonatalogy', by Dr. John D. Isak; 'Recent Trends in Child Neurology', by Dr. Anthony H. Jackson; 'The Endocrinology of Puberty', by Dr. Edward O. Reiter; 'Toward Effective Psychological Assessment and Treatment of Children', by Debra Lobato-Barrera and Malgorzata Ziajka, both from the Department of Psychology of U-Mass.

We want to thank Mrs. Vivian M. Purdy for her unfailing help and encouragement. □

**WALTER J. PACOSA, M.D., CHAIRMAN**
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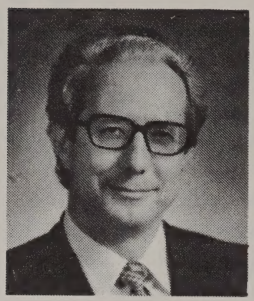

# PRESIDENT'S PAGE

## Attitudes and Laws

This issue of our "Hippocrat" is devoted to a specific subject i.e. "Children and the Practice of Pediatrics". I leave to the specialists analysis of more specific problems, on the other hand as President of our Society I want to outline some directives pertaining to a very frequent situation occuring in our practices. In repeated articles and statements the American Academy of Pediatrics, the American Medical Association, the Society for Adolescent Medicine, the American Academy of Family Practice, Planned Parenthood and others have recommended that physicians be free to provide birth control services to sexually active minors, if necessary without parental consent.

When parental consent is given, there is rarely any legal difficulty in providing such services. However communication between teenager and parent about sexual matters may be difficult even when a good relationship does exist. Legally physicians have nevertheless a sigificant freedom. At least 23 States and the District of Columbia specifically permit that kind of attention to minors. In states where the statutes are ambiguous or restrictive, organizations and individual doctors are openly providing contraceptive services to minors without legal prosecution. No physician or clinic in the United States is known to have been "prosecuted criminally or sued for damages for having examined or treated a minor in connection with contraception". The legal risk at present is best summarized as minimal and unprecedented.

There are, however, physicians, attorneys, legislators and parents who continue to subscribe to the "parent's right" view, i.e. until a teenager is legally adult, age 18, he or she should not be permitted to give self-consent for medical treatment. It is pointed out that the physician is not an alternate parent and should not initiate a discussion about sexual behaviour or the need for contraception. The arguement logically ensues that to provide an adolescent with a contraceptive program encourages sexual activity that can be promiscuous.

We feel that the "parent's rights" view is not sensitive to the basic rights and above all health needs of American youth. Health providers are responsible for meeting health needs. I think that to-day a majority of Americans feel youth should have access to family planning services. □

**FRANCO M. NAVAZIO, M.D.**
**President**

# Tribute From The Governor

February, 1980

It is a privilege and honor to extend my warmest congratulations to the members of the Hampden Medical Society upon the occasion of the 50th Anniversary of the founding of the American Academy of Pediatricians.

On behalf of the citizens of the Commonwealth, I am grateful for the opportunity to express our tribute to the Society members who have dedicated themselves and continue to nurture the highest standards of pediatric medicine. This anniversary celebration arrives at a most fitting time, as the world has just recognized the International Year of the Child during 1979.

This vital and unique celebration for children, which brought far greater concern for the problems and promises inherited by them, has charted an important direction for all of us. However, this international recognition for the Year of the Child must represent only the beginning of the world's responsibility to protect our greatest resource.

To the members of the Hampden Medical Society and the American Academy of Pediatricians, I offer my personal wishes of encouragement for continued success in your work. □

**EDWARD J. KING**
**Governor**

# "Progress in Neonatal/Perinatal Medicine"

The last decade has witnessed major advances in the field of neonatal/perinatal medicine. These advances have resulted in the survival of low birth weight infants, who, a generation ago, had very little chance of surviving. These dramatic improvements result from a better understanding of perinatal pathophysiology and from the development of clinical skills and equipment to support neonatal intensive care.

**Perinatal Medicine Gains**

Current knowledge has simplified the early identification of high risk pregnancies, but their continued evaluation and management has become more complex. The management of high risk pregnancies by a perinatal center maximizes the benefits of new technology and available resources without a duplication of services by each obstetrical or pediatric service in a health region.

The new tests and technologies which have significantly changed the caring practices in obstetrics include the measurement of serum and urinary estriol, amniocentesis, ultra-sound, and electronic monitoring of the fetal heart rate patterns. Serial measurements of serum and urinary estriol provide information regarding fetal health and well being. The safety and effectiveness of amniocentesis has led to its wide-spread use. Amniotic fluid has been analyzed for the number of enzymes and homonal levels with varying degrees of accuracy. The procedure is performed in the second trimester primarily for the purpose of genetic counseling and in the later stages of pregnancy to estimate pulmonary maturity and to monitor the presence of fetal disease. Ultra-sound is a non-invasive diagnostic tool with no known risk to the fetus or the mother. It is widely used for monitoring fetal growth and maturation, for determination of multiple fetuses, for determinging fetal presentation, and for localizing the placenta. Its use in diagnosing fetal dysmorphology is only now beginning. During the ante-natal period, the functional reserve of the utero-placental circulation is assessed by monitoring the responsiveness of fetal heart rate (FHR) by either a non stress contraction test or contraction stress test. Decreased reactivity of the FHR with a non stress test and a positive contraction stress test suggest that fetal health is in jeopardy and delivery of the infant is indicated. Electronic monitoring of the FHR during labor has been shown to decrease the incidence of intrapartum fetal death. Clearly, no single test is capable of detecting all types of disorders that affect the fetus. Each test needs to be considered interms of its reliability, clinical usefulness, cost, as well as its limitations. For this reason, collaboration with or referral to the perinatal center has become an integral part of the management of high risk pregnancies.

High risk pregnancies should be delivered adjacent to the neonatal intensive care unit as maternal transport is far better than infant transport following delivery. This will ensure prompt, appropriate, and adequate care to the high risk neonate. The number of maternal transfers within our region has increased considerably in the past few years.

## Neonatal Medicine Gains

The era of neonatal intensive care units began in 1970. The neonatal intensive care unit at the Baystate Medical Center was opened in 1971. From this time on, we have seen enormous changes in neonatal medicine. This is the result of our better understanding neonatal physiology, availability of sophisticated instrumentation to monitor various body functions in an intricate fashion not dreamed of in the past, and the addition of newer diagnostic and therapeutic tools to intervene and possibly alter the course of the disease process. This has led to ever changing caring practices in the field of neonatal medicine.

Preterm, low birth weight babies are subject to various disorders which complicate the neonatal course as indicated in Table 1. Problems and their severity tend to vary with the degree of prematurity, but ths is not always true. Besides prematurity, intrapartum and delivery room management also influence the course and severity of various problems. Respiratory distress syndrome is still the leading cause of neonatal mortality and morbidity for all premature infants, but for a group of infants who weigh less than 1500 grams, inraventricular hemorrhage has emerged as the major immediate cause of enonatal mortality and morbidity.

Comprehensive care of a tiny, sick infant is often complex and technically difficult. Furthermore, rapid changes require constant monitoring and re-evaluation.

## Outcome

The gains in neonatal and perinatal medicine have substantially reduced neonatal mortality rates to a new low, as shown in Table 2. The result has been most dramatic for the group of infants who weigh between 1000 and 1500 grams at birth as they now have close to an 85% chance of survival. Even the outcome for infants weighing less than 1000 grams at birth has greatly improved in the last few year. Although the survival rate for transferred infants is lower than those born at Wesson Women's Unit, on a year-to-year comparison, their survival rate has shown a slow but steady improvement.

The long-term outlook for the quality of life for the low birth weight infants has also improved greatly since the beginning of neonatal intensive care units. The reported incidence of neurologic handicap is in the range of 10-30%, and it is hoped that with continued advances in neonatal care, this will decrease further.

## Family Support

It is a known fact that the birth of an infant is a joyous occasion for parents; however, the birth of a premature infant who requires admission to the neonatal intensive care unit is a stressful occasion which precipitates an emotional crisis for most parents. This is almost always an unexpected event, and the parents are rarely prepared. Every effort is made to aid the parents in understanding and coping with the reality of the situation. In addition to the physician, the Maternal and Child Health Clinical Nurse Specialist and social worker working as

team members become actively involved in evaluating and assessing each family's needs and making provisions for support during this critical period. In addition, if any unrelated problems are identified, help is offered for these as well. During this critical period, we also offer a Parents' Support Goup which meets twice a week and allows families to interact with other families who are experiencing similar stress. The team members also maintain contact with the family even after the infant is discharged to provide any additional support that may be necessary such as family counseling, enrollment in the follow-up program, and referral to other community services.

**Follow-up**

Graduates of the neonatal intensive care unit meeting certain "at risk" criteria are enrolled in our infant follow-up program. Using federal funds, the program is administered by the Department of Public health, Commonweath of Massachusetts. The purpose of the program is to identify the infants at risk and monitor their continued progrss by close follow-up. These evaluations are performed every six months during the first two years, followed by yearly evaluations up to the age of four. The results of these evaluations are showed with the parents and the physician caring for the infant. The program has been received enthusiastically by parents and the practicing physicians have been most cooperative.

**Future**

Despite these advances in knowledge and care, our principal future task is to reduce the incidence of premature birth and intrauterine growth retardation. □

**BHAVESH L. SHAH, M.D.**
**Director of Neonatal/Perinatal Medicine**
**Baystate Medical Center**

# *COVER STORY*

Pictured on the front cover is Sharon Sulewski, daughter of Mr. and Mrs. Leonard Sulewski of Holyoke, Massachusetts at the age of 21 months. Sharon weighed 879 grams, 30 weeks gestational age, at the time of birth. She was a patient in the Neonatal Intesive Care Unit for 57 days, was then transferred to Providence Hospital for growth and development and dischared home on June 21, 1978.

Photo was prepared for the Hampden Hippocrat by Laurence Flaccus, Public Relations Department, Baystate Medical Center.

# An Agenda For America's Children

**SPRAGUE W. HAZARD, M.D.**

**Chairman - District I**

**American Academy of Pediatrics**

The year 1980 will be a year of celebration and rededication for the American Academy of Pediatrics. This organization was founded 50 years ago when a group of pediatric physicians gathered in Detroit to form a new society whose goal was identified by the founders as:

> "the attainment by all children of the Americas of their full potential for physical, emotional and social health" 1.

On repeated occasions during the formative years of the Academy its leaders continued to emphasize the original aims and present an accountability with regard to the progress being made or recognizing the short comings requiring further attention. A review of these aims is worthwhile in considering today's, "Agenda for America's Children":*

1. to devote the specialty to its main goal - child health and welfare
2. to raise the standards of pediatric education and practice
3. to encourage research in pediatrics
4. to cooperate with all other child health groups for the greater good of children" 2.

* The author wishes to note when the word "children" is used, he is referring to infants, children and adolescents.

From the handful of physicians who comprised the founding body in 1930, the Academy, on its Golden Anniversary, has grown to an excess of 22,000 pediatric physicians in North, Central and South America. Today, the goal is as appropriate as it was at the beginning, June 24, 1930, when the country was just entering the Great Depression. At that time individuals and organizations, dedicated to the rights of children and the advancement of their health and well-being, were few and far between. Still ahead were the great advances in child health, such as the prevention and management of infection as it is now

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known, the miraculous changes wrought by immunization, advances in nutrition and fluid therapy, the development of exciting fields in immunology, the management of neoplastic disease, and the entirely new specialty of child surgery including cardiovascular and neurosurgery.

The list of medical advances in these five decades could go on and on. Only a few have been mentioned. Furthermore, many of the discoveries and approaches to care involving the health of children have led to their utilization in the treatment of adults. It has been an extraordinary half century of achievement. The rapidity and volume of change in our understanding of disease had not been touched in the past and it is not likely that it will ever be matched again over a similar period of time. This is particularly true in terms of both the sheer numbers of human beings who have benefited as well as the quality of change.

Wheras the advances in the medical aspects of child health over the past half century have been nothing short of phenomenal, similar progress has not been made in the socially related prospects for children. This serious, and at times appalling, gap in the well-being of children is currently referred to as "the new morbidity". This title provides a cruel masking of the realities associated with failures in society, and the family, in values and in recognizing that the future of our society is intimtely dependent on how we care for and care about our children.

Epidemic manifestations of these failures are seen all about us. Included in this "new morbidity" is child neglect and abuse, a tragedy involving all strata of society. The dramatic rise in teen-age pregnancies, both wanted and unwanted, is considered by many to have reached epidemic proportions. It is not amenable to simple solution. Accidents, particularly those related to the motor vehicle, continue to go on undiminished. The unmet needs in the adolescent population are alarming and are crying out for attention. The cry is vividly witnessed in the increasing prevalence of suicide and homicide among young people, vandalism, school failure, obesity, cigarette smoking and rising alcoholism.

For those who will pause and consider the lot of so many of our infants, children and young people, it is striking to contrast the miraculous advances in the medical care of these children during this period which has been quite aptly referred to as "the Golden Age of Medicine". The very limited understanding and progress made in solving the social, emotional and environmental inequities adversely affecting the lives of children and young people in America provides a challenge just as complicated and difficult as the medical problems which have been overcome. Indeed, many of them may well be more complicated and difficult to solve. Certainly the wastage of human potential is awesome.

## THE INTERNATIONAL YEAR OF THE CHILD

During 1979 the nations of the world were called upon by the General Assembly of the United Nations to celebrate **The International Year of the Child.** This was to be a celebration by all the nations of the historic resolution, the **Declaration of the Rights of the Child,** proclaimed by the United Nations in 1959. It was to be the 20th birthday of this singular event. Each nation was asked to identify the unmet needs of their children and then to plan and implement programs and services that would have a lasting difference in the health and well-being of these children.

In our own country a National Advisory Council was created. This included representatives of more than one hundred and fifty organizations, all of whom identified themselves as having a convincing concern for the well-being of children and a commitment to advance their cause. The President of the United States appointed the National Commission of the International Year of the Child, 1979 which included twenty-tree distinguished child advocates from representive back-grounds. It was a brave concept, launched with appropriate fanfare. However; little came of the hope. Funding did not materialize. The nation as a political entity and as a conscious force had little to demonstrate that it had been able to ''examine its own programs, national and international, which affect children and use the Year to mobilize the support necessary to implement and provide for those services which best met the needs of all children''. 3. At the end of 1979 the President's Commission was disbanded.

## SPEAK UP FOR CHILDREN

As a manifestation of its commitment to the International Year of the Child during 1979, the American Academy of Pediatrics created its SPEAK UP FOR CHILDREN program. This effort was designed ''to cause a consciousness-raising across the American community concerning the total health and welfare of all its children''. The SPEAK UP FOR CHILDREN program is concerned about the full range of issues affecting children from infant mortality, child abuse, handicapped children, and inadequate foster care to drug abuse and teen-age pregnancy, among many others. However, four health initiatives were chosen for which there was a demonstrated need and in which change could be measured. They are as follows:

ACCIDENT PREVENTION - because accidents are the greatest cause of suffering and death among childrne. For example, 1500 infants and children between the newborn period and four years of age are killed each year in automobile related accidents.

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NUTRITION - because good nutrition starting at conception and continuing through adulthood is basic to a healthy productive life. This is particularly true during child bearing for the mother and her unborn infant and there-after during the formative years of the baby and young child.

IMMUNIZATION - because children must be protected against supposedly "conquered" diseases still capable of producing epidemics. At the onset of the program as many as 35% of children at school entry were incompletely immunized.

HEALTH EDUCATION - because effective health education for children, adolescents and their familes can contribute to happier, healthier and more productive lives. The importance of comprehensive health education for children in all primary and secondary schools is being emphasized.

Several techniques were used in order to achieve the greatest effect possible. Approximately one hundred volunteer pediatric physicians, members of the Academy, who came from all over America were trained by a professional organization as media spokespersons - trained to make effective presentations on television, radio and the speakers platform. A national placement organization was engaged to secure media and speaking opportunities for the spokesperson to discuss one or more of the four health initiatives or other issues regarding the health and well-being of children.

In addition, each of the fifty-four chapters of the Academy within the Untied States developed their own SPEAK UP FOR CHILDREN programs, advancing one or more of the specific health initiatives or special programs of their own. These efforts have been reinforced by the approximately 15,000 North American members of the American Academy of Pediatrics, each of whom were supplied with materials relative to the four health initiatives and the SPEAK UP FOR CHILDREN program. These physicians, working in a variety of settings such as private practice, a community clinic or a university hospital, have been engaged individually in reinforcing this extensive educational program.

At this time it is too early to accurately measure progress resulting from this program. However, it is clear that pediatric physicians can go before the public via a range of media techniques including the generous use of newspapers and magazines. Furthermore, the public has shown a convincing interest in health issues affecting children via such offerings. It is likely that the Academy will continue with a strong public information effort utilizing the skills, commitment and

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experience of practicing pediatric physicians in order to facilitate "the attainment by all children of the Americas of their full potential..."

Among the more specific achievements which can be related to SPEAK UP FOR CHILDREN is the remarkable improvement in immunization levels. Vigorous efforts by Federal and state agencies in reinforcing school entry immunization requirements undoubtedly have had strong influences in the achievement. The rippling effect of the immunization initiative has been impressive, both with regard to infants and preschool children as well as older chilfren and adolescents. Immunization rates for school entry children have risen to 90-95% in contrast to the inexcusable levels of recent years.

Nearly half of the chapters of the Academy have sponsored or supported legislation which required the use of appropriate seat restraints for infants and children. Many have become involved in comprehensive auto safety education programs. Seat rental and exchange programs are under development by several of the chapters.

In the field of nutrition many chapters are working towards the maximum utilization of special nutritional support as made available by the WIC 4. programs in each state. In addition, many chapters are involved in educational programs directed towards encouraging breast feeding. The Canadian Pediatric Society chose the latter as their primary effort in the International Year of the Child. Several chapters are working with coalitions to improve nutrition in school cafeterias.

The importance of joining with other organizations having kindred interest in particularly apparent in the development of comprehensive health education programs in primary and secondary schools, K-12. The PTA has a major effort underway in this endeavor. Eighteen of the fifty-four chapters of the Academy are at work in this promising area for advancing the health understanding of children and their families.

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The momentum generated by the SPEAK UP FOR CHILDREN program has been moved beyond the best hopes of the planners. Begun as a national program, it has now moved into the chapters of the Academy and from there to the very "grass roots" of the organization. The importance of coalitions has been mentioned. It must be emphasized that an energetic group of pediatric physicians cannot do it alone. It will require the joining together of many in a united front to turn the process around - to overcome the indifference and to provide our children and young people with the supports that are their due.

50TH ANNIVERSARY YEAR

The opportunities to further advance the cause begun during the International Year of the Child were recognized with the fortuitous occurrence of the 50th Anniversary of the founding of the American Academy of Pediatrics. Here was a welcome opportunity to continue and to strengthen momentum generated in the previous year.

It was in 1977 that the Academy began to develop a national health program for children in America. The next step was to alert the country as to what would be required in order to overcome many of the problems facing children. After careful examination and study, **10 National Child Health Goals** were identified. These were to serve as a platform for all to examine. It should be noted that four of these goals were the basis for the 1979 SPEAK UP FOR CHILDREN program.

During the 50th Anniversary Year the **10 National Child Health Goals** will become the centerpiece for the anniversary celebration. The Academy will expand its commitment to speak up for children by presenting an **Agenda for America's Children**. This will be the theme - the priority areas, not only for the year's effort, but also it is anticipated for years to come. Furthermore, a process of advocacy and collaboration will be joined whereby many organizations committed to children, including the Academy, will lock arms together to cause change and thereby strengthen the commitment to all of children, young people and their families without which children and countries cannot grow. "If children and their physical, intellectual and emotional development are, in fact, a national priority, society must now recognize the commitment needed to attain the Academy's 10 National Child Health Goals and intensify its drive for improvements in child health care". 5.

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## ALL CHILDREN SHOULD BE WANTED AND BORN TO HEALTHY MOTHERS.

Whereas easy accessibility to a variety of birth control methods is available many babies are born uplanned for and, tragically, unwanted. Children can be chosen other than arrive by chance. The epidemic of teen-age pregnancies, 600,000 now giving birth each year, provides an awesome prospect for mother and child more often than not.

Children should be reared in a home where there is love, happiness and hope. The second epidemic now affecting children is that of abuse and neglect with an estimated one million children suffering physical and emotional abuse, 75% of whom are under 5 years of age.

## ALL CHILDREN SHOULD BE BORN WELL

Infant mortality continues to be a serious problem, particularly in the larger cities as well as in rural areas where support services are not available. The poor and minority populations suffer the most. Although progress has been made in reducing infant mortality, access to acceptable prenatal care, good nutrition, education and other essential supports often is not available in the geographical settings noted above.

## ALL CHILDREN SHOULD BE IMMUNIZED AGAINST THE PREVENTABLE INFECTIOUS DISEASES FOR WHICH THERE ARE RECOMMENDED IMMUNIZATION PROCEDURES

The elimination of small pox and the near elimination of diphtheria and poliomyelitis within the past three to four decades brings promise for controlling other diseases affecting children. Carelessness, lack of understanding and motivation, among other factors, have been associated with significant segments of the child and adolescent opulation not being adequately immunized. The phenomenon has been present in all strata of society. Current efforts to require all pre-school children to be appropriately immunized should be extenaed to younger infants and children. Older children and adolescents are also deserving of every opportunity in this regard.

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## ALL CHILDREN SHOULD HAVE GOOD NUTRITION

Although there is an abundance of food grown in this country, adequate nutrition is not available for many children. Not only is there need for sufficient food, but also there is an equal need for education about foods and the proper kind of foods to avoid malnutriton. The place of this essential component of health education for children, mothers and parents is obvious.

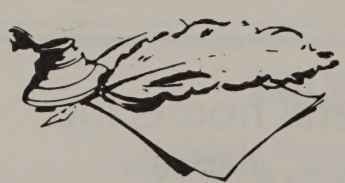
Fortunately there is a returning interst in breast feeding with its many advantages for baby and mother. It is the best nourishment for most healthy babies.

## ALL CHILDREN SHOULD BE EDUCATED ABOUT HEALTH AND THE HEALTH CARE SYSTEM

Good quality comprehensive health education programs in primary and secondary school provides the best opportunity to overcome those illnesses and disorders which relate to life style and the environment. It is these latter two challenges which provide our most difficult problems in improving the health status of the citizens of our country. Generally speaking, the availability of health education in America is sadly deficient. It is far behind other subjects because society and educational systems have not been able to recognize the extraordinary opportunity for progress in health and happiness that can follow good health education, continuous from kindergarten through the 12th grade.

## ALL CHILDREN SHOULD LIVE IN A SAFE ENVIRONMENT

Although appropriate seat restraints can reduce rates in automobile accidents by 90% and serious injuries by 80%, nearly nine out of every ten child passengers ride unprotected. There is an extraordinary opportunity, indeed a responsibility, to sensitize parents and children to the possibility of accidents and their causing serious intrusions on life and the happiness of children. Poisonings, drownings, burns, falls and high risk toys bring suffering and loss to thousands of children and their families each year.

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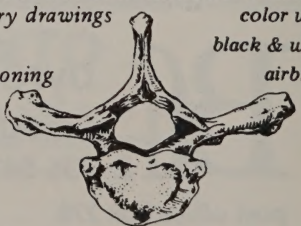

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## ALL CHILDREN WITH CHRONIC HANDICAPS SHOULD BE ABLE TO FUNCTION AT THEIR OPTIMUM LEVEL

There are nine million handicapped children in America, each of which is entitled to reach his or her own full ptential. Well developed and easily accessible diagnostic services must be available, including the opportunity for on-going assessment rather than fixed ''labeling''. Parents must be helped to avoid over-protecting and to understand the importance of a handicapped child learning how to help him or herself.

The vital role of the well-informed physician advocate, serving as the primary care provider cannot be emphasized enough. Here is the essential: In this model coordination of care and reduction of fragmentation has its best opportunity.

## ALL CHILDREN SHOULD LIVE IN A FAMILY SETTING WITH ADEQUATE INCOME TO PROVIDE BASIC NEEDS TO INSURE PHYSICAL AND INTELLECTUAL HEALTH

The family unit has been subjected to a variety of stresses in recent years and has tended to change in its sturcture. Single parent families, both parents employed, parent surrogates, for better or for worse, insufficient income, poor housing and inadequate food are among issues affecting the family structure. Regardless of the pressure on families and the obvious changes which have taken place, the family remains our most precious social institution and every effort should be summoned to strengthen it.

Children, regardless of social strata, have their best chance for developemtn into mature, effective loving adults when surrounded and supported by dependable family. Ways and means for achieving the support of the family is a responsbility of a society that recognizes that it future is decided by the health and well-being of its children.

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## ALL CHILDREN SHOULD LIVE IN AN ENVIRONMENT THAT IS AS FREE AS POSSIBLE FROM CONTAMINANTS

The prevention of disease and disability provides the best opportunity for improving the health status of children and our entire society. We are learning, more and more, that the degenerative disorders of adult life often have their onset in childhood from exposure to a great variety of noxious elements in the air we breathe, the food we eat, the chemicals we ingest and the adverse habits and styles of living we assume.

Children are particularly susceptible to contaminants and to stress. Once again, their future and the future of our nation and our world is directly related to how they are protected from contaminants which originate in their environment.

## ALL ADOLESCENTS AND YOUNG PEOPLE SHOULD LIVE IN A SOCIETAL SETTING THAT RECOGNIZES THEIR SPECIAL HEALTH, PERSONAL AND SOCIAL NEEDS

Over the past two decades adolescents and young people have become increasingly active participants in making decisions about matters affecting their lives. They are being seen less and less as wards of their parents. Society correspondingly has been making adjustments to accommodate this phenomenon, particularly in the field of health care, jurisprudence and legislation.

Privacy, confidentiality and informed consent are being recognized with increasing fequency as justified concers of human beings formerly considred indiscriminately as ''minors''. It should be clearly understood that the relationship of the adolescent and young person to his or her family is every bit as important as it has been - if not more so. However, consonant with the accepted stages of development which the adolescent is moving through; i.e., independent persons struggling with separation conflicts, there needs to be a special understanding of the relationship, trying as it is at times.

In no area is this more required than in the field of adolescent health care, where personal, high quality, non-prejudicial attention to their special health needs is essential. It is a circumstance that can be most challenging to the provider and, in turn, most gratifying.

In celebrating the 50th Anniversary Year of the American Academy of Pediatrics through its emphasis on **An Agenda for America's Children,** it is appropriate to close by quoting from the Preamble of the United Nations Declaration of the Child as it was presented 20 years ago:

''Mankind, owes to the child the best it has to give''

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# SOCIETY IN TRANSITION

Children, the aged, the chronically ill and handicapped, and the socially and economically mal-adroit are all dependent on those who are not similarly categorized. For most tax payers, the numbers of the former are seeming to increase while the numbers of the self-sufficient latter are diminishing. Social and welfare programs abound, but they never seem to do a "complete" or "good" job as viewed by the recipients while the contributors usually see the programs to be overly generous or even unnecessary. Physicians and, for that matter, anyone else in a caring role, know that the societal systems for dependent people are in transition from private to public support. In addition to this transfer of responsibility from family to government, there is the addition of mainstreaming which is designed to bring the dependent person back into society to play as normal a role as possible. The cost benefits of doing this are not proven, but the dictates of the human heart testify to the goodness of this venture. Those two evolutions cost a great deal of money and are cresting at a time when government is retreating from further taxation.

There are some other transitions occurring: increasing materialism despite diminishing energy resources, and increasing demand for private space which probably is a reflection of overall human crowding, increasing incidence and acceptance of violent behavior (either apparent or real), and a retreat from spiritual values at a pace not seen since the early Reformation. All of these changes should be chalked up to the unplanned evolution of human life on earth. Many citizens as well as leaders see these changes as immutable forces totally resistant to rational change even though such planned change is necessary for the health of men and mankind.

If adults perceive their lots to be fixed, future adults (children), learning by example from their parents and leaders, believe themselves to be victims of forces outside of their control. This return to predestination leads youth away from a feeling of responsibility for their own acts and fosters a certain irreverence for society, its material trapping and its long-established value systems. This may be the root of vandalism and global anger that so many young people seem to feel and display.

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Physicians, nurses and other health professionals are called upon increasingly to deal with these transitions as they impact on society. Somehow, these largely behavioral issues are translated to "Medical problems" and are handed over to health caretakers for resolution. In some respects, this may not be too much different than handing over antisocial behavior and mental disorder to the prison system with all of its pejorative limitations and costs. Prisons imprison people and professional health caretakers subvert these "medical problems" to diagnoses, and treatment is formulated to cure or ameliorate the "pathologic" processes. Despite all publicity to the contrary, prevention has not been a hallmark of medical endeavor. The analogy between prisons and professional health care should not be taken too literally. Presumably, many more good things happen from the latter than from the former, but prevention is a benchmark of neither.

The specialty of pediatrics has, from its inception in the latter part of the 19th century, included prevention as one of its principal goals. When the American Academy of Pediatrics was founded in 1930, it, too, carried the shield of prophylaxis high--both for physical illness through adequate nutrition and immunization and for the prevention of behavioral disorder through family counselling and the promulgation of optimal child rearing tactics. Its success in the prevention of certain physical illnesses, particularly infectious ones, has been notable indeed, but its effects on the prevention of behavioral problems are really not ascertainable. Well-child conferences were established to insure immunization and adequate growth, and, as pediatric care evolved, they were to be the sites of counselling as well. A little later, early disease finding (and intervention) also assumed a certain preventative role, but that also was difficult to measure.

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Is it fair that these transitional problems of society as they manifest in childhood are placed on the doorsill of pediatricians and other child health workers? Serious and moderately serious acute and chronic illness are rightfully put in the medical wagon, fill the hospitals, consume dollars, and capture the interst and fancy of scientists and philanthropy. But, does it do any good to bring the school-failing child, the antisocial adolescent, the socially deprived or materially deprived child to a physician for "diagnosis and treatment"? School problems are converted to Chapter 766 evaluations. Disordered behavior is treated with psychotropic drugs. By and large, the medical community has not done well in handling child abuse, school problems, vandalism, petty (and major) crime, teenage conception, smoking, drug usage including alcohol, motivating children for career development, and, at the same time, setting our own house in order and enhancing our own public image. Why is all that? Why can't medicine do all those things?

There are really two reasons. The actual body of knowledge which we need to have in order to prevent those activities is not available. The analogy to physical illness and disability is appropriate. We don't know what causes these deviant and nonadaptive behaviors, so that we cannot prevent them. Our inability to control and prevent infectious disease was equally limited until the vectors of such problems were identified. The second reason has to do with the way medicine (or society) has organized itself. We are paid fee for service to relieve specific symptoms. Physicians find that gratifying, it is remunerative, and the patients salute the doctor for his actions in this regard. There is no similar reward structure for the prevention of a variety of widespread abuses: vacuous television with its violence and its two-dimensional unreality, for the elimination of tobacco products, for the minimal expenditures on career-oriented education (as opposed to our heavy indulgence in global or non-strategic education), and so on. Why is that? It is because we have put forth the view that economic (material) health is fundamentally more important than human (sociobiological) health, either of the individual, or of the nation or world.

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This rambling discussion has attempted to outline the problems of the present-day pediatrician (physician) in his attempts to cure or prevent problems which are outside of his domain. These problems arise because human evolution is rooted in the transitions that are outlined at the beginning of this piece. Economic health has been placed ahead of personal health and, in the long run, that will be a serious problem for America and for the world. In a single stroke of his pen, the President saved more lives and prevented more disability than the entire program to eliminate paralytic poliomyelitis--by limiting highway speed to 55 miles per hour. Are there other enactments that are possible? There surely are and it is up to all of us to lead to their execution. We, who are concerned with health, particularly as it applies to the individual, cannot fail to take action which will lead to collective good health. To some, this will look like an infringement of their ''rights''. Perhaps we should ask ourselves more seriously about our rights, our health, and the future of man. □

P.S. **December 4, 1979:** To underscore the last sentence, witness the trampling to death of eleven young adults in Cincinnati last evening while gaining entry to a Rock Concert. The concert went on as scheduled!

**THOMAS M. TEREE, M.D.**

# ''APATHY''

Having been offered the opportunity to write a regular article in this journal, I intended this month to exhort its readers once again to support their Academy - its programs, and its library.

I thought to remind you of the serious financial plight of this venerable institution faces entering another year of rising expenses and declining revenues. Having reemphasized the obvious value of a local library of considerable scope, and the social value to the physicians of the area, I would appeal for wider support from the District Medical Society, and local hospitals whose members and staffs the Academy has served so well and for so long.g.

However, writing to meet a deadline is an inconvenience I can do without. Like all of you, I am busy with my practice and countless other things compete for my attention. Probably very few will read this page, and fewer still would be moved to action by its contents. No doubt someone else will fill this space.

The Academy of Medicine is rather like a fine restaurant of the intellect, offering a rich and varied fare. If lack of interest forces it to close its doors, someone will undoubtedly open a MacDonalds - faster, cheaper and more ''modern'' if not as meaningful. After all, that is progress --- why fight it?

Perhaps next month I'll write something (if I get around to it). □

**ROBERT L. SEAVER, M.D.**
**Presdient**

# *Contraception for the Teenager*

Most of us are very frightened by the thought of adolescent contraception. We still feel that by providing teenagers with protection against pregnancy we, in effect, are providing them a license to be sexually active and, even worse, to be promiscuous. The opposite, however, is the case. Numerous studies have shown that the more knowledgeable teenagers are about their sexuality and contraception the less sexually active they are. The fear of pregnancy is not a very good deterrent to sexual activity.

According to Zelnik and Kantner, in 1976 25% of the 10.2 million females, aged 15-19, were sexually active and did not use contraception 83% of the unintended first pregnancies of teenagers occured in the absence of contraception.

Most teenagers when requesting contraception are really seeking information about sexuality in general. If we have not come to grips with our own sexuality we cannot expect to have come to grips with adolescent sexuality. We should attempt to discuss their sexual behavior in a non-judgemental manner without surrendering our own moral code. We must explain to them the consequences of irresponsible sexual behavior. However, refusing to provide contraception to a teenager who has made the decision to engage in sexual activity is similar to refusing to treat a prostitute for veneral disease until she promises to reform her ways. Failure to provide contraception to a teenager who truly needs it is condeming her to an unwanted pregnancy.

Unfortunately, no contraception has proven superior for any population group including teenagers. Sporadic and unpremeditated sexual activity, emotional factors, lack of privacy, and non-compliance effect the choice of a contraceptive for this particular age group. The bottom line when prescribing a contraceptive for any patient is the risk-benefit ration. If the need to avoid pregnancy is great and the result of that pregnancy are markedly disruptive then assuming the greater risks of the most effective contraceptives is justified.

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The most effective means of contraception are the pill, IUD, and barrier methods such as diaphragm and condom. Other methods, such as foam, withdrawl, and rhythm are not as effective and should be discouraged as standard fare for teenagers.

Oral contraceptives are the most effective means of all in the patient motivated to take a pill every day. Unfortunately, the pill also has a high morbidity, although its associated mortality is not nearly as high as that associated with an adolescent pregnancy carried to term.

When prescribing the pill, we must screen the adolescent for definite contraindications, i.e. stroke, phlebitis, pulmonary embolism, proven migraine, epilepsy, liver disease, estrogen dependent neoplasias, and pregnancy. The adolescent who has not established a definite menstrual cycle, or who has a history of oligomenorrhea is not a good candidate for oral contraceptives. In effect, we would be suppressing an already inadequate pituitary - ovarian - uterine axis.

A teenager who selects the pill should also be instructed in a readily available barrier method such as condoms or single dose foam as a backup method. Because of the high incidence of non-compliance in the teenage population, pregnancy frequently occurs due to lack of a backup method when a teenager forgets two or three pills.

The next most effective method is the IUD. It has the advantage of requiring very little compliance -- two visits to a gynecologist or clinic and then six or twelve month checkups and contraception is provided.

The disadvantage of the IUD is the increase in dysmenorrhea and menorrhagia associated with their use. These two symptoms are usual chief complaints in adolescent gynecological clinics, and they seem to be intensified by the IUD. The new, smaller, copper-bearing IUD's seem to be better tolerated by nulligravidas with less dysmenorrhea, heavy bleeding, and spontaneous expulsion.

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The greatest problem with the IUD is the increased risk of pelvic inflammatory disease, the incidence of which is increased in nulligravidas. IUD's are associated with a rather unusual unilateral pelvic inflammatory disease. Because of the increased incidence of PID with resultant sterility, the use of the IUD for the adolescent is not recommended if other methods of contraception are acceptable.

The remaining methods, exclusive of the pill and IUD have the disadvantage of being used related to the act of intercourse and are therefore plagued with high degree of non-compliance. Because of the high degree of motivation required for the proper use of these other methods, their effectiveness for adolescents is questioned.

In the mature, responsible and informed adolescent, the diaphragm can be a successful method of contraception. If a teenager is taught the use of a diaphragm correctly and she uses it at each and every sexual encounter, it can provide her satisfactory protection throughout her entire reproductive years. The condom has the advantage of being available without the need for medical services. It, also, involves the male partner in the responsibility for preventing the unwanted pregnancy. The condom, because of its ready accessability and the ease with which it can be carried with you, can provide excellent protection for the sporadic and unplanned sexual encounter. The condom combined with vaginal foam provides an effectiveness which rivals that of the IUD.

Withdrawl, rhythm and foam (except as a backup to other methods) are so ineffective in the usual adolescent's social situation that they, in effect, provide a false sense of security rather than true protection from unwanted pregnancy.

Post-coital contraception should be used only in emergencies and then should be prescribed within 24 hrs. but certainly no later than 72 hrs. Prior pregnancy must be ruled out! The possible effects on the fetus and possibility of abortion if post-coital contraception fails must be explained. If abortion is not a viable alternative, then post-coital contraception should be avoided.

"Adolescents require contraceptive services that are adapted to their special needs. Teenagers who want those services respond best to those which are dignified, reliable, prompt, confidential, free or low-cost, easy to reach, and available after school hours. They appreciate being offered the opportunity for individual or group counseling on sexuality, parent and partner relationships, and contraceptives. In any effort to effect positive changes in adolescent sexual behavior and lower the rate of unintended pregnancy the professional should first gain the teenagers trust. To gain this trust the professional must be honest, open, and understanding of the teenager's feelings and motivation. When trust is gained, the teenager may be willing to accept and apply practical advice." 1.

1. "Adolescent Perinatal Health," The American College of Obstetricians and Gynecologists; Task Force on Adolescent Pregnancy; 1979. □

**TERRENCE M. O'NEILL, M.D.**

# *Letter To The Editor*

The Department of Public Welfare continues to place unreasonable and unsupportable rules and regulations on the back of the Welfare Providers. Some of these are totally intolerable. For instance take Section 311 B of MAS-ALL-2 letter dated November 1979, which was mailed to all of our offices. If a patient is seen on a private basis and pays the fee indicated, the D.P.W. can force us to give the patient his money back. How can this occur you might ask. Under the above section and section 203 it is stated that if a patient is retroactively placed on welfare all providers must refund fees paid during this period and apply for welfare payments. In addition the welfare payment must be accepted as payment in full. We all know that many patients receive care which is comprehensive, detailed, and lengthy and is not adequately compensated by the meager and inadequate welfare payments. It is one thing to see a patient knowing he is a welfare recipient and give care realizing that it is almost an act of charity. It is another thing all together to see a patient on a private basis and 90 days later to be told to give the money back.

Anyone who is a welfare provider is bound by the above rule. The only way to have such rules changed by the bureaucrats is to refuse to continue in the system. Under Title XIX the D.P.W. is mandated to maintain a system which compensates physicians in a fair, reasonable and equitable manner. This has not been done and will not be done until we bring pressure upon the D.P.W. Our prime weapon is to refuse to reapply for vendor status this spring. If we are foolish enough to continue as welfare vendors this and other equally reprehensible rules, will be forced down our throats.

It is a mistake to think that the D.P.W. is planning a reasonable and equitably program for dealing with physicians. Strong and decisive action now will prevent disaster in a few years. □

**JOSEPH R. STIRALACCI, M.D.**

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# PUBLIC RELATIONS
## The Media, The Patient, and The Physician

A recent Television Editorial broadcast a few days after the birth of the new decade brings to the fore a frequent problem in medical public relations. In the following letter, read by Mr. Putnam on Channel 22, a patient complains of excessive and inappropriate billing to insurance companies for medical treatment. Since this is an important public relations and physicans' image concern, we are printing the letter in its entirety to gather comment from our membership. We would welcome your reactions and advice as to how best to respond to such broadsides now and in the future. □

**BERNARD BLOOM, M.D.**
**Public Relations Chairman**

**A recent letter reads:**

On several occasions you have defended the rise in hospital costs and explained that government regulations which make it necessary for the paying patient to pay more so as to subsidize the cost of those for whom the state pays only a part of the actual expenses. I do not challenge your position. However, there is evidence that surgeons, have a tendency at times to gouge the insurance companies when they know that their patient is covered by a policy. In the last year, two such cases have come to my attention, and since the premiums on my health insurance depend in the ultimate analysis on the amount the companies must dish out, I am disturbed.

In the first instance, I visited a surgeon for treatment of a fissure. The job was done with highest efficiency by a most thoughful and kindly professional, and was carried out under local anesthesia in less then fifteen minutes spent in the doctor's office as a follow-up. The direct cost to me was nothing, but I noted that Blue Cross-Blue Shield was billed over $300 for this surgery, which it paid in full.

The second case involved my wife, and is more recent. She broke her little toe. The orthopedist, also a kindly, highly qualified man,

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charged the insurance company $26 for x-rays, which may not be excessive, then put a bit of tape around the toe to relieve pressure, and said there was very little more he could do about the condition, which in time would cure itself. Total time at the doctor's office; ten minutes. Charge by doctor to insurance company; $105 for "surgery."

I do not know of any other profession or business where charges for personal services are anywhere near that high, and if most of the rest of us could charge that kind of fee for our attention we would all be millionaires I also suspect that, in an earlier age, when patients were not covered by insurance, the attending physician, faithful to his Hippocratic oath, would have charged at most $50 and $25 respectively in the above cases to the patient for his services. In short, I suspect that insurance coverage, private or public, vastly enhances the temptation for the surgeon to charge every cent the traffic can bear, since he feels it is the insurance organization, Federal, State or private, and not the patient, which must bear the expense. This is one reason I look askance at Senator Kennedy's proposals for a national health insurance program, because, judging from my experience, the only thing it will do is impoverish the taxpayers and enrich a tiny minority of professionals who have had the good fortune to attend medical school, and more particularly those fewer who went on to become surgeons.

This is not to be taken as an indictment of the medical profession. Our doctors and surgeons, for the most part, work hard and well. They deserve a reward for the long hours they spend preparing for their profession. They merit high pay and an excellent living. But at the same time, if they are to continue to consider themselves as professionals rather than as businessmen something must be done to persuade them to stop fee practices which in the long run will be ruinous to the insurance companies, the government, the taxpayers, and finally to themselves. □


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